Investigation of a complaint against the Northern Health and Social Care Trust

Report Reference: 202002533

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

I received a complaint regarding the actions of the Northern Health and Social Care Trust (the Trust). The complaint concerns a visit by the complainant with an ill relative (the patient) in the Emergency Department (ED) at Causeway Hospital. The ED visit took place during Covid restrictions. The complainant said she agreed with a triage nurse that she should accompany the patient to the ED doctor's assessment due to his memory difficulties. The complainant said an ED doctor subsequently assessed the patient without her being present. The Trust clinicians discharged the patient but he had to attend ED again the next day. The complainant believed the failure to allow her to accompany the patient during the ED Doctor's assessment had an adverse impact on the patient's care and treatment.

The investigation identified shortcomings in the Trust's documentation and communication with the complainant in relation to the need for her to attend with the patient at the ED Doctor's assessment, given he had memory problems and was poor at providing information on his medical history and symptoms. Notwithstanding this failing, the investigation did not find any failing with the care and treatment the patient received. The investigation also identified a lack of an appropriate and effective procedure for Trust staff to "flag" patients who required assistance with communication and to provide medical history. The investigation also established the learning from the complaint was inadequate to bring about significant improvement to prevent recurrence of the failing identified. I am satisfied that the maladministration identified caused the complainant to experience the injustice of upset, frustration and uncertainty. Although ultimately, there was no impact to the patient's care and treatment, he lost the opportunity to be accompanied by his relative and was distressed. I acknowledge this was also an upsetting experience for the complainant.

I recommended the Trust apologises to the complainant and the patient. I also recommended the Trust should continue to provide further staff training to identify

and assist patients with poor memory and communication difficulties. The Trust should also utilise the new electronic record system to ensure it is “flagging” those needing assistance with communication.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust). The complainant accompanied her ill relative (the patient) to the Emergency Department (ED) at Causeway Hospital on 11 April 2021. She was concerned the patient could not provide an accurate account of his condition, symptoms and medical history.

Background

2. The patient had a relevant past medical history dating back to 2010 including physical and mental health issues. In April 2021, he began to complain of potential cardiac issues. The complainant accompanied the patient to Causeway Hospital ED on 11 April 2021. The NHS were under covid restrictions at the time regarding social distancing, reduced accompanying adult/visitors and mask wearing. The complainant attended the triage nurse with the patient. She explained his symptoms, medical history and that he is not a reliable historian of either. The triage nurse assured her she would ensure that the complainant accompanied the patient while the ED doctor assessed him. When the patient was called from the waiting room for blood tests and an ECG[1] the complainant was not allowed to accompany him. The patient was assessed by an ED doctor without the complainant present.

3. When the complainant left the waiting area to check on the patient, she found the patient confused and wandering in the corridor. She became aware the doctor had assessed the patient. The complainant again raised the issue of accompanying the patient to provide an accurate history. Another ED doctor assessed the patient, and he was discharged.

4. The next day, 12 April 2021, the patient experienced similar symptoms and he reattended at Causeway Hospital ED accompanied by the complainant. On this occasion the complainant accompanied the patient during assessment by the triage nurse. The complainant was able to relay an accurate account of his medical history and symptoms. Staff repeated blood tests and an ECG. An ED doctor assessed the

[1] ECG is an electrocardiogram - a simple test that can be used to check your heart's rhythm and electrical activity.

patient with the complainant present. The ED doctor discharged the patient home with a referral to the rapid assessment chest pain clinic.

5. The patient attended on 14 April 2021 at the Rapid Assessment Chest Pain Clinic. The complainant makes no complaint regarding that attendance and treatment.

6. At a subsequent Causeway Hospital ED visit some weeks later the complainant experienced similar problems while accompanying another family member with difficulties relaying their medical history and symptoms. The complainant said this shows any remedial action the Trust took was insufficient to resolve the issue. This investigation did not look at the specific details of that subsequent attendance.

Issues of complaint

7. The issues of complaint accepted for investigation were:

Issue 1: Whether the care and treatment provided to the patient on 11 April 2021 in the ED was reasonable and appropriate and in accordance with relevant policies and guidance?

i) In particular this will consider the support the patient received on 11 April 2021.

Issue 2: Whether the Trust follow up action, following ED attendance on 11 April 2021, was reasonable and appropriate? -

i) This will consider whether the Trust implemented appropriate learning from the complaint to prevent recurrence

INVESTIGATION METHODOLOGY

8. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

9. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- Nurse MSc in Advanced Clinical Practice \ BSc in Nursing Practice with over 20 years' experience in nursing and management across emergency and critical care areas. (ED Nurse IPA)
- Consultant in Emergency Medicine MD MPH FRCEM with over 24 years of experience in emergency medicine. (ED Doctor IPA)

10. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs both provided 'advice'; however how I weighed this advice, within the context of this complaint is a matter for my discretion.

Relevant Standards and Guidance

11. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles[2], set put at Appendices one and two to this report.:

- The Principles of Good Administration
- The Principles of Good Complaints Handling

12. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

13. The specific standards and guidance relevant to this complaint are:

- Nursing and Midwifery Council (NMC) Code of Conduct (2018) – (NMC Code)
- Royal College Emergency Medicine: Consultant Sign Off (2017)

[2] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- Department of Health Visitor Guidance, February 2021. (Visitor Guidance)
- Trust Internal ED Covid Guidance, (2021) - (Trust Covid guidance)
- Trust Complaints and Service User Feedback Policy and Procedure (2020) – (Trust Complaint Policy)
- Department of Health, Health and Social Care Complaints Guidance (2021) – (Department Complaints Guidance)

14. I did not include all the information obtained during the investigation in this report, but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant was content with the report. The Trust provided comments on the draft recommendations. These are addressed at paragraph 52.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient on 11 April 2021 in the ED was reasonable and appropriate and in accordance with relevant policies and guidance?

i) In particular this will consider the support the patient received on 11 April 2021.

Detail of Complaint

15. The complainant said she was very unhappy she was not able to attend the ED doctor assessment on 11 April 2021 with the patient. The ED triage nurse had agreed she could accompany the patient. She felt without a clear and accurate account of his medical history and symptoms, which she said the patient was unable to provide, his condition could not be accurately assessed, diagnosed and treated.

Evidence Considered

Policies and Guidance

16. I considered the following policies and guidance as part of investigation enquiries:

- Royal College Emergency Medicine: Consultant Sign Off (2017)
- Visitor guidance.
- Trust Covid guidance.

The Trust's response to investigation enquiries

17. In response to investigation enquiries regarding the failure to provide appropriate care and treatment, the Trust stated '…*restrictions were in place in the Emergency Department… [the patient] was assessed by the doctor who was not aware that [the complainant] had expressed the need to be present with [the patient].'*

18. The Trust further stated '*whilst it was agreed [complainant] could accompany her the patient, the triage nurse unfortunately did not record this information and cannot recall passing the information to other staff, as per her normal practice. At this stage the nurse in charge was waiting until the doctor was going to assess [the patient] and then she had the intention of going and bringing [the complainant] in. However, the nurse forgot to say to the doctor that [the complainant] was to be present when they were carrying out their assessment.'*

19. The Trust acknowledged '*the triage nurse did not document or pass on relevant information to the remaining team. However, the doctor did subsequently discuss [the patient] symptoms and management with [the complainant]. It should be noted this was a busy department in the middle of a pandemic.'* The complainant disputes there was any discussion of the patient's symptoms and management.

20. In response to enquiries regarding the impact of the failure to have the complainant present during assessment resulted in them having to return the next day, the Trust stated '*blood test and other investigations were normal. [the patient] was discharged but as a safety net was advised to reattend if his symptoms did not settle. [the patient] further reattended the ED the next day complaining of chest pain. Further tests were also inconclusive. …on both occasions the assessment was thorough and*

competent.'

21. The Trust further stated that '*It is documented at triage on the Symphony system (Emergency Department electronic system) that [the patient] had impaired mobility and cognitive impairment.'*

22. While addressing her complaint, the Trust told the complainant it had reinforced training with staff and was planning further modifications to the Symphony electronic record system to "flag" patients with special needs.

Medical records

Independent Professional Advice

23. In relation to the patient's triage in the ED on 11 April 2021, the ED Nurse IPA advised '*The ED nurse should have been aware of the patient's memory issues and communicated this with colleagues The ED nurse should have been aware of the ED arrangements during the pandemic that states one person can accompany a vulnerable adult. All registered nurses must use excellent communication skills. Their communication must always be safe, effective, compassionate, and respectful. NMC code of conduct states nurses should work cooperatively and to achieve this they must maintain effective communication with colleagues.*

24. The ED Nurse IPA further advised *'During the pandemic the ED arrangements in the documents reviewed were that one person only to accompany the patient where the patient is unable to understand or communicate with staff such as a child, vulnerable adult or palliative patient – [the patient] is a vulnerable adult due to his significant memory impairment, the complainant therefore could have been present when [the patient] had initial tests. The ED nurse's (triage and nurse in charge) actions were not appropriate as communication between colleagues failed to take place.'*

25. In response to the communication failure, the ED Nurse IPA advised '*The lack of communication lead to the patient having initial tests, consultation, and examination without the complainant present. The impact this had on the patient is reported by*

the complainant in the email dated 25th May 2021 – [the patient] was reported to be agitated and distressed.'

26. The ED Doctor IPA advised '*There is no documented information about the information from the [complainant], about the patient's cognitive issues. Even accounting for COVID-19 restrictions in place at the time, in a patient with cognitive issues, it would be appropriate to have a relative present with the patient to ensure that a full and complete history was obtained from the patient.'* There is no record of a discussion with the complainant.

27. In relation to whether the patient could provide a full and proper medical history, the ED Nurse IPA advised '*on the basis of the information provided the patient had significant cognitive and communication difficulties which would have impaired the [the patient's] ability to provide a full and complete medical history.'*

28. The ED Doctor IPA further advised '*Overall, the care and treatment received was reasonable and in line with relevant policies and guidance, with the exception of support provided.'*

29. The ED Doctor IPA identified in particular, '*in line with Royal College of Emergency Medicine guidance around unscheduled ED reattendance within 72 hours, ED doctor 2 discussed the case with the duty ED consultant and agreed a treatment plan.*

Analysis and Findings

30. The investigation focused on the complainant's attendance at Causeway Hospital ED with the patient on 11 April 2021 and whether he was allowed adequate support from the complainant during the attendance.

31. The Trust had implemented the Department's visitor guidance and produced the internal ED Trust guidance in the form of a notice. It is clear the notice envisaged an adult could accompany a patient requiring assistance because of communication difficulties.

32. The investigation established the complainant attended with the patient at the initial attendance with the triage nurse on 11 April 2021. The Trust does not dispute that the triage nurse agreed that the complainant would attend with the patient for the subsequent doctor assessment. This was necessary as the patient had memory problems and was a poor historian of his medical history and symptoms. The triage nurse did not record this information on the written record. The Trust also accepted the Nurse in charge at the ED did not relay to the assessing doctor the need for the complainant to attend with the patient. The complainant was not facilitated to be present with the patient during his assessment. This would have helped in obtaining an accurate history of the patient's condition. This may also have assisted in ensuring the patient did not become distressed, agitated or attempt to wander off. The Nurse in charge did not record this information on the written record. I consider these to be four instances of failed (written and verbal) communication. Clearly the Trust did not have appropriate procedures in place that ensured effective communication (written and verbal) to ensure patients with memory difficulties were identified and supported properly. I uphold this part of the complaint.

33. I considered and accept the IPA ED Nurse and ED Doctor advice '*The ED nurse's (triage and nurse in charge) actions were not appropriate as communication between colleagues failed to take place'* and *'Even accounting for COVID-19 restrictions in place at the time, in a patient with cognitive issues, it would be appropriate to have a relative present with the patient to ensure that a full and complete history was obtained from the patient.'*

34. I considered the ED Doctor IPA advised *'the patient received appropriate care during their attendances on 11th… April 2021*' and '*there is no evidence that the treatment plan would have been any different had a history also been taken from the accompanying relative*'. I am satisfied there was no negative impact on the patient's care and treatment flowing from the failure. However, I consider the patient was not supported adequately due to the absence of his relative during the assessment process. After his reattendance on 12 April the complainant did attend while he was assessed by the ED Doctor with appropriate safety netting and referral to the clinic on 14 April.

35. In considering the actions of the Trust staff, I had regard to the Principles of Good Administration. The First Principle of Good Administration requires public bodies to 'Get it Right' by acting in accordance with the public body's policy and guidance (published or internal). The Second Principle of Good Administration requires public bodies to be 'customer focused' by informing customers what they can expect and what the public body expects of them, and by dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances. I consider the Trust should have followed its own stated internal guidance to allow the complainant to accompany the patient. I consider this failure to constitute maladministration. I uphold this issue of the complaint. I considered whether the failing identified caused an injustice to the patient and the complainant. I am satisfied the complainant sustained the injustice of upset as I note she referred to the anxiety this situation caused her. She also said it affected the patient's health. However, I note the ED Doctor IPA advised '*Overall, the care and treatment received was reasonable and in line with relevant policies and guidance.'* I am satisfied therefore there was ultimately no impact on the patient's health. However, I am satisfied that he lost the opportunity to be supported during the assessment process and I accept that he appeared agitated and distressed when the complainant found him in the corridor.

Issue 2: Whether the Trust follow up action, following ED attendance on 11 April 2021, was reasonable and appropriate? -

i) This will consider whether the Trust implemented appropriate learning from the complaint to prevent recurrence

Detail of Complaint

36. The Trust's response to the complainant under local resolution left the complainant dissatisfied. The Trust suggested it had implemented learning and improvement as a result of the complaint. The complainant was told staff would be reminded of the internal trust policy on admission of an adult with a patient who had memory issues. Trust management in the ED were working with the IT department to "flag" patients who require additional help or assistance. However, the complainant felt the changes to the electronic record system and staff training were impractical and insufficient.

Evidence Considered

Policies and Guidance

37. I considered the following policies and guidance as part of investigation enquiries:
    - Trust Complaint Policy
    - Department Complaints Guidance

The Trust's response to investigation enquiries

38. The Trust stated that '*It is documented at triage on the Symphony system (Emergency Department electronic system) that [the patient] had impaired mobility and cognitive impairment.'*

39. The Trust held a *Delirium Awareness training day in May 2021 and all staff were encouraged to attend. A Care of the Elderly/Frailty training day for ED (medical and nursing) was held on 10 June 2021…and the Trust stated 'a "special needs" alert facility was added to the Symphony system.'*

40. The Trust provided details of the amendment to the Symphony electronic record system. This allows the user to input information under a sub heading of "special needs." The computer record notes this patient had "cognitive impairment." The ED triage nurse made this entry at the time of his attendance.

Complaint records

41. I considered the complaints records from the Trust.

Independent Professional Advice

42. The ED Nurse IPA advised *'During busy periods verbal communication can and did breakdown. The Trust stated it was working towards Improvements in the ED symphony computerised system and the process for identifying vulnerable patients. If these improvements have now been made and implemented, this would help reduce the risk of communication breakdown.'*

Analysis and Findings

43. The need to allow someone such as a relative or carer to accompany a patient with memory issues while in the ED is clear and accepted. Even during Covid period the visiting guidance provided for this practice. The Trust had a notice to this effect in the ED waiting area. Clearly, in the complainant's experience this did not happen. The steps the Trust have taken to learn lessons from this complaint involve work on the electronic records system, training and direct reinforcement of the internal visiting guidance with staff.

44. I am not clear that the Trust has made any further change to the Symphony system since April 2021 to address identifying patients with communication issues. I not clear whether the current electronic system is effective or efficient when compared to a solution such as simply applying a sticker to written records. This would "flag" a patient requiring assistance due to communication difficulties which would be recognisable and available to all staff not limited solely to the electronic record system. The electronic record of "special needs" is not readily visible on screen and requires the user to seek any such record. The "special needs" box was completed for the patient on 11 April 2021 attendance but clearly did not achieve the desired outcome. This would lead me to believe the Trust has not made any relevant change to the Symphony system following the complaint.

45. The Trust reinforcement of the Visitor Guidance to staff would be transient, that is it happens on a "one off" or occasional basis and would be unlikely to achieve a permanent change to behaviour. In fact, the complainant personally outlined a repeat of her experience with the patient, with another family member within weeks at the same ED.

46. I considered the Trust response that Delirium and Old Age/Frailty training had been provided to ED staff. I am not clear that such training would be sufficiently focused on actions staff should take to identify, document and treat patients who may have communication or memory difficulties, such as ensuring an available relative or carer attended with them.

47. In considering the complaint learning for the Trust, I had regard to the Trust complaint policy which states '*learning from complaints is important.'* The Trust were

unable to provide clear evidence to support identified areas of failure, learning and improvement arising from the complaint. Therefore, I am not satisfied the Trust did put sufficient measures in place to ensure this did not happen again.

48. I also considered the Department Complaint Guidance which states 'to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. '

49. In considering the actions of the Trust, I had regard to the Principles of Good Administration and Good Complaints Handling. The second Principle of Good Administration requires public bodies to be 'customer focused' by dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances. I also had regard to the sixth Principle of Good Complaints Handling which requires public bodies to 'seek continuous improvement' by ensuring it learns lessons to improve services and performance. I consider the Trust should have conducted a proper analysis of the available methods of "flagging" patients with communication needs and implemented a combination of practical and training solutions. I consider this constitutes maladministration. I consider the Trust should reinforce by training for ED staff specifically addressing patients with communication or memory difficulties to ensure such a situation does not happen again. I uphold this issue of the complaint.

50. As a consequence of the failures identified, I considered the impact this had on the complainant. The complainant lacked faith in the Trust attempts to ensure such problems did not recur. I consider the complainant felt frustrated and uncertain arising from the failings identified.

Trust comments on draft report

51. The Trust responded to my draft report with comments on two areas in my provisional recommendations. In relation to training the Trust indicated that ED staff were provided with further training on dementia, including communication and memory difficulties. The Trust also facilitated 'Just a Minute' ED staff training to

address barriers to communication for those with a hidden disability. The Trust also indicated that the Symphony electronic records system is due to be replaced with the Encompass system with full implementation by Autumn 2024, so that further adaptation of Symphony was impracticable. I have taken account of those comments and adjusted my recommendations accordingly.

CONCLUSION

52. I received a complaint about the actions of the Trust. The complainant said there was a failure to communicate the need for her to accompany the patient, while he was assessed for chest pains. The complainant said the communication failure had a negative impact on her and the patient. The complainant said similar difficulties repeated some weeks after she was told the Trust had taken remedial steps.

53. The investigation found maladministration in the following areas:

- Staff did not document in writing and communicate that it was necessary for the complainant to accompany the patient as he had memory difficulties.
- The Trust's failure to follow internal guidance on ED visits permitting an adult to accompany a patient with communication issues.
- The Trust's failure to follow policy on complaints learning.

I am satisfied that the maladministration identified caused the complainant to experience the injustice of upset frustration and uncertainty.

54. The investigation established the Trust's follow up care and treatment was reasonable.

Recommendations

55. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the maladministration identified (within one month of the date of this report).

56. I recommend that the Trust shares the outcome of this investigation with relevant staff in the ED highlighting the failings identified.

57. I recommend that the Trust should continue to provide regular training and written reinforcement to ED staff clarifying how to identify patients with communication or memory difficulties and take appropriate action including ensuring they are accompanied where an adult is available.

58. I recommend that the Trust should emphasise during training for ED staff on the new Encompass electronic records system, which is being rolled out over the next twelve months, the need to "flag" patients with communication and memory issues.

59. I recommend that the Trust implements an action plan to incorporate these recommendations with any process changes. The Trust should provide me with an update within **six** months of the date of my final report, including additional training dates/materials, numbers of attendees and examples of written reinforcement.

MARGARET KELLY
Ombudsman

November 2023

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.